New Jersey Department of Health and Senior Services
Division of Aging and Community Services
Enhanced Community Options Medicaid Waiver

OFFICE OF WAIVER AND PROGRAM ADMINISTRATION REFERRAL

Client's Name: _____ Social Security No.: _____

Address: _____ Medicaid No.: _____

_____ Date of Birth: _____

Telephone No.: _____ Spend Down: ☐Yes ☐No

Referred By (Name and Title): _____ Date: _____

Agency/Facility: _____ Telephone No.: _____

Contact Person Name
(if different from above): _____ Telephone No.: _____

Diagnosis: _____

_____

_____

Reason for Referral: _____

_____

Care Needs: _____

_____

Community and Family Supports: _____

Pertinent Social Information (include present living situation): _____

_____

_____

Financial Information:

a. Monthly Income _____ b. Resources (bank accounts, stocks, bonds, etc.:

Social Security _____ _____

Pension _____ _____

Other _____ _____

Total _____ _____

c. Face Value of Life Insurance Policy(ies) (if known)

Face Value: $ _____ Cash Value: $ _____

NOTE: If found eligible for these programs, there may be a cost share to the client which is dependent upon his/her income and medical expenses.